2005 Atlantic Hurricane Season

Millions of lives were impacted by the 2005 Atlantic hurricane season. It was the "worst case scenario" for the United States.

The Atlantic hurricanes have had the most impact to the United States over the last few years. The Atlantic hurricane season officially begins on June 1. For the United States, the peak hurricane threat exists from mid-August to late October, although the official hurricane season extends through November. On average each year, ten tropical storms, six of which become hurricanes, develop in the Atlantic Ocean, Caribbean Sea or Gulf of Mexico. In a typical three-year span, the U.S. coastline is struck on average five times by hurricanes, two of which will be designated as major hurricanes.

During the 2005 season, there were a record-breaking 26 named tropical storms and 13 hurricanes. Three of these stand out amongst the rest…Katrina, Rita and Wilma. Within weeks of each other, and with incredible intensity and force, Hurricanes Katrina and Rita changed the face of many parts of the U.S. Gulf Coast. We are all aware of the massive damage and loss of life caused during these storms. Close on their heels was Hurricane Wilma-coming less than a month after Rita made landfall. Wilma set numerous records for both strength and seasonal activity. Wilma was the twenty-second storm, thirteenth hurricane, sixth major hurricane, and fourth Category 5 hurricane of the record-breaking season. All three storms (Rita, Katrina and Wilma) had a massive impact on the physical landscape, the local population, and the region's economy. Approximately 90,000 square miles were hit by the storm - roughly the size of Great Britain - and directly effecting 1.5 million people. Wilma also effected eleven countries with winds or rainfall, more than any other hurricane in recent history.

More than a thousand people lost their lives as a result of these hurricanes, and millions more were left battered, broken, displaced and/or homeless. In late December 05, the Red Cross estimated that over one-third of approximately 171,000 residences in the Mississippi coastal counties were either destroyed or rendered totally uninhabitable due to Hurricane Katrina alone. However, while entire neighborhoods were being wiped out by heavy rains, storm surges or flood waters from breeched levees, communities and neighbors from across the country were mobilizing.

U.S. Military Response to the Disaster

As the disasters grew to previously unimaginable proportions, the coordinated efforts of a multitude of disaster response agencies, the Department of Defense and humanitarian organizations continued working to keep up and meet the needs of those impacted by the storms. Weeks after Hurricane Katrina pummeled Louisiana, Mississippi and Alabama, the nation was faced with the challenge of helping a region recover and mend. Our military branches of service were called upon to provide assistance. Over 70,000 Active Duty and National Guard Personnel combined were deployed to the hurricane-effected areas. Over 400 aircraft and 20 Navy ships also participated in support of the relief efforts. More than $88 billion in federal aid was allocated for relief, recovery and rebuilding efforts in direct support of the victims of the storms.

The Department of Defense and the Military Health System worked with many federal agencies, state and local officials, and entire communities to bring much needed healthcare, food, clothing, shelter, and hope to the ravaged Gulf Coast region. Over 2,000 military medical personnel were deployed to the effected areas to provide healthcare during the disaster relief efforts. They moved more than 10,000 patients, including more than 2,600 by air evacuation, and directly provided healthcare services to over 6000 patients. Field hospitals were set up in numerous locations as well as sending the USNS Comfort to aid in the relief operation.

Healthcare for Our Hurricane-Impacted Military Beneficiaries

There were many people directly impacted by the hurricanes. Of these, over 136,000 military members and their families were victims. These military beneficiaries were relocated to approximately 474 evacuee sites across the United States. However, many stayed in their own communities or came back as soon as they could.

TRICARE Management Activity is the Department of Defense agency responsible for managing the military's health care plan, TRICARE. TRICARE has three regions within the continental United States - TRICARE North, West and South.

The entire gulf coast (the area hit by the hurricanes) falls under TRICARE's South Region. The South Region includes Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, and Texas (excluding the extreme western El Paso area) and has more than 2.7 million beneficiaries eligible for care in the military system.

The TRICARE Regional Office-South (TRO-S), headquarted in San Antonio, Texas, is the governmental agency responsible for overseeing the TRICARE program for the 10-state region. Humana Military Healthcare Services (HMHS) is the managed care support contractor that administers the TRICARE program for the South Region. When it became evident major storms would be hitting the gulf coast, immediate action was taken by both TRO-S and HMHS to assist effected military beneficiaries and to put in place a system that would provide continued access to care.

Not only beneficiaries were effected by the hurricanes. There were numerous military bases and medical treatment facilities (MTFs) located throughout the area that were also impacted. This further decreased patient care access and also displaced many of our military healthcare providers, MTF and HMHS staff members. In addition, the network providers in the civilian communities were also effected. There are some who have still not been able to return and set up practice due to the damage to their own property.

Healthcare Initiatives Taken

Intensive efforts to provide education and assurance to our gulf south military beneficiaries became a top priority. Evacuees were relocated all across the United States so numerous means of communication were necessary to reach these individuals and their families. Since many displaced evacuees were in temporary shelters set up by the Red Cross, HMHS quickly dispatched many of their staff members to visit the shelters across the region. The purpose of the visits was to locate eligible military beneficiaries and discuss issues relating to their individual healthcare concerns. Posters, pocket cards, magnets and other resources were widely distributed, providing resource numbers and other important information.

Numerous web sites were created by the contractor, TRICARE Management Activity, HMHS and TRO-S with the sole purpose of providing education not only to the beneficiaries but to the network providers, MTFs caring for the patients and staff members of both HMHS and our MTFs unable to make it back to their duty stations. The sites were updated daily, hourly if possible, as information was obtained. The websites contained maps of the effected areas, handy resource numbers, open TRICARE Service Center locations, status of effected MTFs, status of network providers (both primary care managers and specialists), HIPAA privacy rules, and the process for obtaining prescriptions, medical supplies, glasses, and most importantly, health care.

Many plans, programs and initiatives were put into place during the disaster recovery efforts. Here are a few of the significant actions taken:

1. Authorization of blanket referral waivers to assist beneficiaries who were displaced by Hurricanes Rita and Katrina. The blanket referral waiver allowed beneficiaries to seek care from any TRICARE-authorized provider for a limited time. The blanket referrals allowed TRICARE Prime beneficiaries to receive non-

emergency, non-mental health care from providers other than their assigned primary care manager without having to obtain a referral. TRICARE beneficiaries covered by the temporary blanket referrals were not charged point-of-service deductibles and cost shares for these services.

2. The suspension of pharmacy co-pays through Oct. 31, 2005 for TRICARE beneficiaries impacted by both hurricanes.

3. During the first week in November, HMHS mailed a postcard to over 34,000 Prime beneficiary households advising them to change PCMs if they were establishing themselves in a new location. The toll-free phone numbers for all three contractors were provided in the event their new location was in a new region, and beneficiaries were advised that referral waivers had been extended.

4. Case management of those patients with more complex needs.

5. Provider Representatives continually made efforts to locate all network providers by making phone calls to providers who they could not reach. This effort was to provide information on temporary processes in place effecting healthcare delivery and the claims process. It was also a good method to provide updated statuses to the web of which providers were open for business. The internal HMHS Online Provider Locator continues to be updated by Provider Representatives to reflect providers that are confirmed operational, non-operational, or unable to contact.

6. Daily meetings were held between the MCSC, TRO-S and TRICARE Management Activity to closely follow issues that arose affecting our beneficiaries and quickly worked to streamline resolution.

Contingency Planning for the Future

The benefits of advance planning and preparation in the event of emergencies and mass deployments cannot be overstated. There have been many lessons learned from the hurricanes of 2005. Contingency planning must be accomplished as an ongoing effort. Contingency and communication plans are now in place at all levels of the military health system. Some of these plans are actually identified as contractual requirements for the managed care support contractors of TRICARE. The managed care support contract requires each regional contractor to develop and implement a contingency program working with the MTFs and the Regional Director. As part of the contingency program, joint contingency exercises between MTFs, the TROs, and the MCSC are used to enhance MTF/TRO/MCSC interoperability and communications. Because the South Region was the focus of the hurricanes, a brief discussion on their contingency planning efforts will be overviewed.

There are three types of main contingency plans for the region: the TRICARE South Regional Contingency Plan, the HMHS Regional Contingency Plan and each MTF are to have a plan. The TRICARE South Regional Contingency Plan provides information and details on how HMHS plans to respond to contingencies that impact the ability of the MTFs to provide medical care to their beneficiaries.

The MTF contingency plans provide essential input to HMHS for network development. Their plans help to ensure continued availability of services to our beneficiaries during times of need. The MTF contingency plans identify MTF capabilities which may need to be transferred to the MCSC network in the event of staff deployments, regional or local disasters, or other contingencies.

The HMHS Contingency Plan is very detailed and explains their involvement at the regional to local levels. Contingency operations require a collaborative effort between MTFs and their MCSC to ensure that health care service is continuously available. The HMHS plan is required to be implemented within forty-eight (48) hours of being notified by the TRICARE Regional Office Director.

TRO-S Contingency Exercises
For TRO-S, three major tests of their contingency programs have occurred during the last twelve months. These real world events have validated the importance of our contingency program in maintaining service to our beneficiaries. They have also highlighted a couple of specific areas requiring improvement.

The HMHS plan is adjusted each option year based on lessons learned from MTF (installation)-level and regional tabletop exercises conducted during the year, as well as any real contingency operations conducted during the option year. They are required to participate in up to two Regionally Coordinated Table Top Contingency Exercises and up to two MTF (installation) level contingency exercises each year for the purpose of testing their plan.

The success of the HMHS plan is measured by their ability to ensure health care services are continuously available to TRICARE-eligible beneficiaries when an MTF responds to war, deployments, training, contingencies, special operations, or any other situations that may impact the MTF's ability to provide care and services.

First, improved input on capabilities and deployable billets from MTFs including remotely located subordinate clinics is necessary so HMHS can plan to support the MTFs in the event of a major deployment or other contingency. In this effort language has been tightened in the Option Period 3 Contingency Plan to require that MTFs list separately subordinate clinics and health care centers outside 60 minutes' drive time from the parent MTF. Aggregated provider listings allowed in previous years' Contingency Plans did not give HMHS enough geographically relevant information when an outlying clinic's operations may have been affected by a contingent event.

Secondly, the contract requires HMHS' participation in all MTFs' installation level contingency exercises twice per year. The old adage, "you play like you practice" certainly applies. MTFs that rehearse and practice their reactions to contingencies will certainly benefit from the experience should the real thing unfortunately come along. Although 2 exercises are specified in the contract, more practice certainly does not hurt. Since HMHS is required to implement the contingency program within 48 hours when notified of an actual contingency, and exercises provide them with the opportunity to test run their procedures in a controlled, learning environment where beneficiaries are not at risk for adverse effects. MTFs are highly encouraged to include HMHS in all contingency exercises.

MTF input into annual Contingency Plans is essential to ensure the adequacy of the network when deployments, contingencies, natural disasters or other events impact the MTF's ability to provide care to their enrollees. Prior planning also reduces costs and allows development of a thorough contingency plan which can be rapidly implemented. Contingency operations are not a new phenomenon, and will almost certainly effect the beneficiaries in the South region again. With accurate, up-to-date contingency plans and advance rehearsal in contingency operations through MTF and regional exercises, the effects can be significantly minimized and normal operations resumed in a more timely fashion.